

Department of Health and Human Services  
Centers for Medicare and Medicaid Services

Form Approved  
OMB 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

TO: REGIONAL ADMINISTRATOR  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:  
0 1 - 0 2 5

2. STATE  
Illinois

3. PROGRAM IDENTIFICATION: TITLE XIX OF  
THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
December 3, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.272 Section 1902 (a) (13) (A) of the  
Social Security Act

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-C, Page 1

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ (2.25 Million)  
b. FFY \_\_\_\_\_ \$ \_\_\_\_\_

9. PAGE NUMBER OF THE SUPERSEDED PLAN  
SECTION OR ATTACHMENT (If Applicable):

Attachment 4.19-C, Page 1

10. SUBJECT OF AMENDMENT:

PAYMENT POLICY FOR RESERVING BEDS IN INPATIENT FACILITIES

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:  
Not submitted for review  
by prior approval.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Jackie Garner

14. TITLE:

Director

15. DATE SUBMITTED:

16. RETURN TO:

Illinois Department of Public Aid  
201 South Grand Avenue East, 3rd Floor  
Springfield, Illinois 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

11/1/01

18. DATE APPROVED:

12/10/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

21. TYPED NAME:

Cheryl Harris

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE: Associate Regional Administrator  
Division of Medicaid and Children's Health

23. REMARKS:

Attachment 4.19-C  
Page 1State Illinois

## PAYMENT POLICY FOR RESERVING BEDS IN INPATIENT FACILITIES

12/95 Bed reserve is allowed for all Medicaid group care residents of nursing facilities as follows:

Payment for bed reserve is allowed for hospitalization and home visits. All bed reserve requests must:

- ==12/01 - be authorized by a physician ~~(in the case of hospitalization, the physician must anticipate that the hospitalization will not exceed ten days);~~
- be limited to residents who desire to return to the same facility; and
- be limited to facilities that have a 93 percent or higher occupancy level.

==12/01 Payment for bed reserve is allowed for resident hospitalization not exceeding ~~ten (10)~~ five (5) days per hospital stay, ~~only when the physician indicates that it would be traumatic for the resident not to return to the same facility.~~ The day the resident is transferred to the hospital is the first day of the ~~ten-day~~ reserve period.

==12/01 Payment for bed reserve is allowed for a home visit when a physician indicates the home visit is therapeutically beneficial for the resident. Bed reserve is limited to ~~seven (7)~~ five (5) consecutive or non-consecutive days in a calendar month ~~or ten (10) nonconsecutive days within a calendar month.~~ Home visits may be extended with the approval of the Department.

Bed reserve days for home visits are computed on a midnight basis. If a resident is in the facility any part of the day, it is not counted as a bed reserve day and the facility will receive the resident's current Medicaid per diem.

==12/01 Payment for approved bed reserve is a daily rate of ~~75~~ 33 percent of a resident's current Medicaid per diem.

In no facility is the number of vacant beds to be less than the number of beds identified for residents allowed bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.

TN # 01-25APPROVAL DATE 12-3-01EFFECTIVE DATE 12-3-01

SUPERCEDES

TN # 95-12